

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
CATEGORICALLY NEEDY GROUP(S): ALL**OFFICIAL**

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1. Inpatient Hospital Services

With Limitations (See Supplement Pages 1 and 2 to Attachment 3.1-A, Addendum Page 1).

2. Outpatient Hospital Services

- a. No more than one (1) visit per day to the same outpatient clinic.
- b. No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient.

3. Other Laboratory and X-Ray Services

No limitation on services.

4. a. No Limitations4. b. EPSDT

With Limitations as described in the other benefit areas except where such limitations are precluded for EPSDT purposes by Federal Regulation.

4. c. Family Planning Services

The Department will not pay for any procedures or services of an unproven, experimental or research nature.

5. Physicians' Services

- a. The Department will not pay for any procedures or services of any unproven, experimental or research nature.
- b. The Department will pay for no more than four (4) routine medical visits during any twelve (12) month period for Title XIX patients residing in homes for the aged.
- c. The Department will pay for no more than one radiation treatment per day.
- d. The Department will not pay for a brainstem evoked response recording and a computerized axial tomography scan with myelography when performed within three (3) months of each other.
- e. The Department will not pay for transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis.

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
CATEGORICALLY NEEDY GROUP(S): ALL**OFFICIAL**

- a. Diagnostic, therapeutic or treatment procedures, and inpatient hospital stays for experimental, cosmetic, research, social or educational purposes;
- b. Any services or items furnished for which the provider does not usually charge;
- c. The day of discharge or transfer;
- d. Leave of Absence (LOA) or Pass without medical permission;
- e. Leave of Absence (LOA) or Pass with and without Medical Permission, when the Title XIX patient is out of the hospital at the time of the census count (12 midnight);
- f. Emergency room services provided on the same day as inpatient admission;
- g. Hospital inpatient stay is not covered when the following procedures or services are performed:
  1. Tuboplasty and sterilization reversal
  2. Implantation of nuclear-powered pacemaker
  3. Nuclear powered pacemakers
  4. Inpatient charges related to autopsy
  5. All services or procedures of a plastic or cosmetic nature performed for reconstructive purposes, including but not limited to the following:  
lipectomy, hair transplant, rhinoplasty, dermabrasion, chemabrasion.
  6. Transsexual surgical procedures for gender change or reassignment or treatment preparatory to transsexual procedures (e.g. hormone therapy and electrolysis).
  7. The Department will not pay for a hospital stay, medical services or procedures in the treatment of obesity, including gastric stapling.

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Supplement Page 2  
to Addendum Page 1  
to Attachment 3.1-A

State of Connecticut

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
CATEGORICALLY NEEDY GROUP(S): ALL

- h. With the exception of a CT Scan no Title XIX reimbursement will be made to a hospital for medical services provided to an inpatient outside of the per diem daily rate.
- i. The Department will not pay for drugs included in the Drug Efficacy Study Implementation (DESI) Program that the Food and Drug Administration has proposed to withdraw from the market in a notice of opportunity for hearing.
- j. Admissions and day(s)-of-care that do not meet established requirements for medically necessary acute care inpatient hospital services.
- k. Weekend admittances (Friday/Saturday), or discharges (Sunday/Monday) unless they are medically necessary.
- l. Payment will be denied for general hospital inpatient recipients if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided they do not meet the medically necessary or utilization review standard.

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To Attachment 3.1AAMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
Categorically NEEDY GROUP(S): ALL

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- f. The Department will not pay for the treatment of obesity.
  - g. The Department will not pay for any immunizations, biological products and other products available to physicians free of charge from the Connecticut State Department of Health Services.
  - h. The Department will not pay for any examinations and laboratory tests for preventable diseases which are furnished free of charge by the Connecticut State Department of Health Services.
  - i. The Department will not pay for information provided by a physician over the telephone.
  - j. The Department will not pay for cosmetic surgery.
  - k. The Department will not pay for an office visit for the sole purpose of the patient obtaining a prescription where the need for the prescription has already been determined.
  - l. The Department will not pay for cancelled office visits or for appointments not kept.
  - m. Services are limited to those listed in the Department's fee schedule.
  - n. No more than one (1) psychiatric evaluation in any twelve (12) month period per provider for the same recipient.
  - o. No more than one (1) psychiatric therapy visit of the same type per day.
  - p. No more than eight (8) persons per psychiatric group therapy session.
  - q. Payment will be denied for physicians' services to general hospital recipients if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided they do not meet the medically necessary or utilization review standard.

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State CONNECTICUT

Addendum Page 3  
To Attachment 3.1 A

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
Categorically NEEDY GROUP(S): ALL

6. Medical Care and any other type of Remedial Care

a. Optometrists

- (1) Contact lenses will be covered, when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses for Unilateral Aphakia (after second eye is operated on a spectacle, lenticular cataract Rx will be supplied instead of additional contact lenses), Keratoconus, Corneal Transplant, and High Anisometropia.
- (2) Soft contact lenses will not be covered unless necessary for treatment of corneal disease.
- (3) Prescription sun glasses will be covered when light sensitivity which will hinder driving or seriously handicap the outdoor activity of a patient is evident.
- (4) Trifocals will be covered only when the patient has a special need due to job training program or extenuating circumstances.
- (5) Oversize lens will be covered only when needed for physiological reasons, and not for cosmetic reasons.
- (6) Services and materials covered are limited to those listed in the Department's fee schedule.
- (7) The maximum time covered for reconditioning and refitting of ocular prosthesis is one hour.
- (8) Optometric services not covered:
  - (a) Extended wear contact lenses.
  - (b) A spare pair of eyeglasses.

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to Attachment 3.1A

State Connecticut

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
TO CATEGORICALLY NEEDY GROUPS: All

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b. Psychologists

- (1) No more than one (1) diagnostic interview or psychodiagnostic evaluation procedure of the same type in any twelve (12) month period per psychologist for the same recipient.
- (2) No more than one (1) therapy visit of the same type per day.
- (3) No more than eight (8) persons per group therapy session.
- (4) No more than one (1) staff consultation for any recipient per psychologist.

c. Podiatry

- (1) Payment will not be made for orthotic and/or corrective arch supports for recipients under age five.
- (2) Orthotic and/or corrective arch supports will be paid once every two years.

d. Chiropractic Services

- (1) X-rays provided by a chiropractor are not covered.

e. Naturopathic Services

- (1) The administration of dehydrated foods is not covered.

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State Connecticut

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUPS: ALL

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f. Nurse Practitioner Services

Services are limited to those listed in the Connecticut State Department of Social Services Regulation for Nurse Practitioner Services.

g. Dental Hygienist Services

Services are limited to those preventive and therapeutic services performed by a dental hygienist with two (2) years of experience functioning within his or her scope of practice as defined under state law and licensed pursuant to Chapter 379a of the Connecticut General Statutes (CGS). When performed in a public health facility, as defined in Section 20-1261(a)(2) of the general statutes, these services may be performed under the general supervision of a licensed dentist as defined in Section 20-1261(a)(1) of the general statutes. The dental hygienist shall be responsible for: (1) referral for treatment of any patient with needs outside of the dental hygienist's scope of practice, and (2) coordination of the referral process to dentists licensed pursuant to Chapter 379 of the general statutes.

Service Limitations:

Services are limited to those services relevant to a dental hygienist's scope of practice and listed in the Connecticut State Department of Social Services Medical Services Policy for Dental Services.

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Addendum Page 5  
To Attachment 3.1A

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
Categorically NEEDY GROUP(S): ALL

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7. Home Health Services

Payment for home health services is not covered when:

The patient is receiving or is capable of receiving outpatient services of the same type.

The patient is receiving services which are not medically necessary.

The patient is receiving the same home health services from more than one agency.

The patient is receiving home health services for a condition that is not medical in nature, e.g., obesity.

The patient is receiving home health services for a condition that otherwise would not be treated under the State plan.

The home health services are for well child care, for prenatal or post-partum care.

The procedure or service is of an unproven, experimental or research nature.

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CATEGORICALLY NEEDY GROUP(S): ALL

- a. Intermittent or Part Time Nursing Services provided by a home health agency or by a registered nurse when no home health agency exists in the area. When two or more nursing patients in the same household are receiving skilled nursing services, the full rate will be paid for one patient, and one-half the rate for every other patient receiving care.
- b. Home Health Aide Services provided by a Home Health Agency. Home Health aide services in excess of twenty hours per week must be cost effective.
- c. Medical supplies, equipment and appliances suitable for use in the home.  
  
These supplies, equipment and appliances are provided to patients in their own home through medical supply and equipment providers.
- d. Physical therapy, occupational therapy, speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Covered services include the services of a licensed speech pathologist or therapist employed by or under contract to a home health agency.

8. Private Duty Nursing Not Provided

9. Free-standing Clinic Services

The Department will not pay for any procedure or service which is of an unproven, experimental or research nature.

Payment will be denied for the services of physicians in free standing clinics to general hospital inpatient recipients if the Department determines that the medical care, treatment or services does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided they do not meet the medically necessary or utilization review standards.

a. Mental Health Clinic Services

- (1) No more than one (1) therapy session of the same type per day per clinic for the same recipient.
- (2) No more than one (1) psychiatric/psychological evaluation in any twelve (12) month period per provider for the same recipient.
- (3) No more than eight (8) persons per group therapy session.

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CATEGORICALLY NEEDY GROUP(S): ALL**OFFICIAL**

- (4) No more than one (1) methadone maintenance program clinic visit will be paid per week for recipient.

b. Rehabilitation Clinics

- (1) No more than one (1) complete evaluation per year involving the same treatment modality per provider for the same recipient.
- (2) No more than one (1) full impedance battery, tympanometry test or electronystagmography per provider clinic for the same recipient per year.
- (3) No more than one (1) treatment session per day for the same procedure, per provider clinic for the same recipient, except for speech therapy which is limited to 1½ hours per day.

c. Dental Clinics

Limitations: See Dental Services, Section 10.

d. Medical Clinic

(1) Family Planning Services

- (a) No more than one (1) form of birth control per recipient per visit.
- (b) No more than one (1) visit per day.
- (c) No more than one (1) initial visit per provider per recipient.

(2) Other Clinic Services

No more than one (1) visit per day, except when the patient, after the first encounter, suffers a new illness or injury requiring additional diagnosis or treatment.

10. Dental Services

a. Dental Services Covered

- (1) No more than one (1) intraoral, complete series radiographs during any three (3) year period per provider for the same recipient.

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